

V. 5 - 6

CALIFORNIA'S HEALTH

WILTON L. HALVERSON, M.D.
DIRECTOR OF PUBLIC HEALTH

STATE DEPARTMENT OF PUBLIC HEALTH
ESTABLISHED APRIL 15, 1870

PUBLISHED SEMI-MONTHLY

ENTERED AS SECOND-CLASS MATTER FEB. 21, 1922, AT THE POST OFFICE AT SACRAMENTO, CALIFORNIA, UNDER THE ACT OF AUG. 24, 1912. ACCEPTANCE FOR MAILING AT THE SPECIAL RATE OF POSTAGE PROVIDED FOR IN SECTION 1103, ACT OF OCT. 3, 1917

SACRAMENTO (14), 681 J STREET, 2-4711

SAN FRANCISCO (2), 668 PHELAN BLDG., 760 MARKET ST., UN 8700

LOS ANGELES (12), STATE OFFICE BLDG., 217 W. FIRST ST., MA 1271

VOLUME 5, Number 1

JULY 15, 1947

ANN WILSON HAYNES, Editor
JEROME GROSSMAN, Assistant

STATE BOARD OF PUBLIC HEALTH

DR. CHARLES E. SMITH, President
San Francisco

DR. SANFORD M. MOOSE
San Francisco

DR. JAMES F. RINEHART, Vice President
San Francisco

DR. ERROL R. KING
Riverside

DR. ELMER BELT
Los Angeles

DR. SAMUEL J. McCLENDON
San Diego

DR. HARRY E. HENDERSON
Santa Barbara

DR. WILTON L. HALVERSON,
Executive Officer
San Francisco

THE SEEDS AND FRUITS OF IN-SERVICE TRAINING*

GEORGE T. PALMER, DR. P. H., Consultant in Public Health Administration

Effective public health work calls for trained people. For the professional staff this means a broad academic training followed by specialized training in public health. More and more we are recognizing the value also of a brief period of field training to smooth the transition from the university to the job.

But training cannot stop here. Inevitably it continues on the job, whether we recognize it and cultivate it formally or not. The field of public health, as with so many other fields, is in a continuous state of change. New knowledge is evolving from new discoveries, from constant additions to former discoveries, from new adaptations in procedures in the light of new discoveries, from experience, from studies, from the reassessment of values and end results. Long existing needs are being rerecognized and given a place in the growing program. Additional financial support is being received to implement programs. The public health program cannot be static, nor can learning and training have an end point.

Learning, of course, takes place naturally during work experience. Thus we may say that in-service training of a sort is being carried on in all health departments. But the pace of learning can be stepped up and learning itself can be guided into more productive channels by conscious and planned effort. If we recognize and value certain desirable goals in learning, and are not content with the haphazards of experience alone as a teaching method, then we must develop a plan of training that heads toward these goals.

What are these desirable goals? The primary goal, it seems to me, is to develop people. Improvement in people is the first step toward an improved program.

* Presented before the Health Education Conference, sponsored by the Public Health Education Section, Western Branch, American Public Health Association, San Francisco, May 25, 1947.

In developing people, it must be decided first what are the qualities and skills that are desired in a staff. What does the administrator want to see developed?

Next we shall need to know the avenue of development. What is it that brings forth responses in people? What is it that the human beings who constitute a staff want? Perhaps a road to staff development can be found through the wants of a staff.

With goals and staff wants identified, then we may consider how one goes about to set up or implement an in-service training program.

THE GOALS OF STAFF DEVELOPMENT

We want the people on a staff, do we not, to know their field, to keep up to date.

But our objective, you will remember, is to develop people. Something more is necessary than content and information.

Some of the things we would like to see in a staff are—

A deep personal interest in the job;

A recognition on their part of the need for a certain uniformity in procedure and yet an alertness to ways of improving methods of work;

An awareness that improvement means change, and yet a fearlessness of constructive change;

An understanding of the need for acquiring supporting data for opinions;

An understanding of how to get along with people—colleagues and the public;

Some discernment into why people behave as they do.

THE NATURAL WANTS OF A STAFF

Some, at least, of the major wants of staff members, over and beyond remuneration and security, are—

- To be respected as a person;
- To be regarded as a responsible member of the team;
- To experience satisfactions in their work;
- To receive recognition;
- To have their ideas welcomed;
- To be thought important enough to be included in planning and in carrying out new programs.

These are natural, fundamental, universal desires of human beings. They are the foundations of good morale, of interest, of lift, of drive. Their recognition calls for an awareness on the part of the director that these desires are existent, are not to be ignored and that these wants can be used profitably for the development of a strong, forward looking staff.

Too much cannot be said for giving people the opportunity for self expression and participation in the planning of a program. All will not respond equally, but the growth process is afforded a chance to operate within the climate of such opportunity. We know well that the denial of these satisfactions discourages initiative and the desire for growth.

The problem here is one of keeping a recognition of these values in the forefront of thinking, not only on the part of the director but of his subchiefs and supervisors. Perhaps framed mottoes on the wall are not the answer to keeping these principles alive, but in some more subtle fashion they must not be permitted to be forgotten.

Responsible participation in planning to the limit of a person's capability not only brings a sense of satisfaction but it converts a director's program or a supervisor's program into a staff program. There is a heightened interest upon the part of an individual in the success of a program which that individual has had a part in constructing. It is then his program, his program to carry out, his program to support.

IMPLEMENTATION OF IN-SERVICE TRAINING

W.M.
The starting point in an in-service training program is an interest and a willingness on the part of the staff chief to provide the time and the facilities for its establishment. We must not gloss over this point. Interest is one thing, but standing firmly behind training efforts is something else. For a staff training program does take the time of workers away from the routine duties of the day. Time siphoned off from routine is the greatest objection to overcome. When pressures mount in the load carried it takes loyal faith in the virtues of a training program to hold to the line.

There are temptations to postpone and to encroach upon the training program in favor of seemingly more pressing duties.

The spirit behind in-service training must rest with the chief but for the immediate leader or better, the director of arrangements, someone on the staff must be designated, and the health educator is the logical person professionally to step into this role.

TYPES OF IN-SERVICE TRAINING

a. Orientation Training. One form of in-service training is the orientation of new members of the staff. Here is an opportunity during the first week or month of service to display to the newcomers the scope of the department's field of work.

Visits to the various offices, laboratories and clinics, with brief informative remarks by the heads of different services open a vista to the newcomer of the importance of his new occupation. Favorable impressions ought to be created at this time. The various chiefs are on trial in a sense and their presentations ought to be seriously considered in advance. The orientation program, crowded as it is into a few days, is a full one for the newly employed worker. Remarks ought to focus on the purposes and breadth and interesting features of the work rather than being a drab recital of secondary details.

Time, again, is the potential barrier to the orientation program for it does take time. The health educator as the guide and consultant must think and learn from experience how best to design the program to sustain the feeling of value for all concerned and thus avoid the possible sense of intrusion in the minds of bureau chiefs and the sense of "nothing gained" on the part of the trainees.

b. Staff Meetings. Meetings of the staff, the entire staff or limited to a single professional group, are instrumental in in-service training. Meetings can be set up for different purposes however.

The staff conference may be confined to instructions or interpretations by a chief or supervisor. While the instructions in themselves may constitute a part of staff training, many additional learning values are introduced if staff members are encouraged to discuss freely any and all materials that are presented. The learning features are reduced under a dominating presiding officer who "tells" but does not welcome criticisms or comments.

Two other types of meetings are of value in the training program. One is the "informational" meeting planned for the purpose of enlarging the entire staff's horizons on present day thinking and new developments in their own and related fields. Experts outside the health department may be brought in to present

recent developments in such specialized fields as orthopedics or cardiology or medical social work or housing. This type of meeting brings home to the staff a realization that other professional people and groups in the community are likewise engaged in important undertakings and that reliable sources of information can be found outside the health department.

The seminar type of meeting serves still a different purpose. It is neither a staff conference nor an informational meeting but an occasion in which individuals are chosen to prepare original material for presentation and to lead discussions. Such occasions likewise provide the experience of defending one's views in the face of challenges. This contributes to the growth of the individual and assists him in distinguishing between personal and professional criticism. It is this type of meeting which provides the satisfaction of recognition, of being respected as a person, of being a member of the team.

c. Staff Participation in Solving Problems. The in-service training program cannot rest wholly on meetings however. There is also the learning experience which a small group of persons may derive from delving into a specific problem. Here is an opportunity in which several nurses, sanitarians and physicians may work together in developing new techniques, or in seeking bases for forming new policies. This may call for an analysis of office records, or the gathering of field records or conducting interviews with people or even in making time studies of procedures or operations.

It is in such special studies that a group learns the value of consultation. Many studies will call for team work. Perhaps the nursing supervisor, the health educator and the public health analyst can assist in planning the study and in securing and evaluating data. From such studies the group also learns the value of orderly procedures and the difference between subjective and objective appraisal.

Perhaps the most important outcomes, however, which stem from the problem solving method is through participation in working on a problem. Subtle changes are developed in the attitudes of staff members who hitherto had seemed impervious to change by other methods of in-service training such as lectures or seminars.

d. Demonstrations. Still another method of in-service training which yields good returns is the demonstration. Learning is facilitated through seeing a thing done first hand. A demonstration center for teaching purposes may be established in which a small staff works together in setting up new procedures and trying out new ideas. As these practices prove their worth in

the hands of a few staff members, their usefulness may be extended by rotating other staff members through the center. This gives others a chance to learn not by hearing the procedures described but through actual participation in the procedures.

e. Day-to-Day In-Service Training. We have been discussing the special, formal methods of in-service training through meetings, seminars, special projects for group work on problems, and demonstrations. But objectives of in-service training can be cultivated also in a less formal manner by the relationships established between bureau chief and staff, and supervisor and staff in their day-to-day routine tasks.

Respect for the employee as an individual, recognition, provision for participation in group planning, special tasks, assignments to represent the staff on committees and at meetings—all these expressions of interest are in themselves part of an in-service training program that stimulate growth and team work in staff members.

All these measures that we have discussed are desirable in implanting a true spirit of team play. They will encourage staff members to *undo* the wrappings on their hidden ideas about program betterment.

Team play or working in concert is a principle highly stressed by the leaders of progressive thought in industry. In a recent number of the *Technology Review*,* Alvin Brown, Vice President for Finance in the Johns-Manville Corporation points out that "It has been a long time since the individual, unaided by his fellows, has been a significant factor in industrial enterprise. It has even come to the point where research in the laboratory—yes, even the thinker in his study—depends for success on the association of effort. The time is past when one man, alone, except in unusual cases, can make any significant contribution to human progress."

He sums up the idea of collaborative working in these words: "Human progress depends upon concert of endeavor. For all that we have, for all that we hope to gain, we depend upon associated effort. Civilization depends upon the endeavor of *individuals associated in their respective enterprises.*"

STAFF RESPONSIBILITY

The health educator has been referred to as the logical leader in helping the director and the supervisory staff with these various types of educational effort. His work is with the community, yes, but with the staff of a health department as well. As a leader in a program, however, it should be understood that the health educator is in no way to be held responsible for staff training within a bureau. His services are

* May, 1947—"Organization—A Neglected Science."

those of a guide and consultant. His contribution is in furnishing suggestions on suitable educational techniques to meet the problems outlined in a bureau training program. The chief of sanitation may elect to set up an educational course for food handlers. He should look upon the health educator as a consultant in this enterprise, one who as a resourceful person can assist in suggesting appropriate teaching methods, and in recommending new teaching materials. This assistance throughout is vital in view of the fact that so much dependence has been placed hitherto solely on the lecture style of teaching.

In summarizing may I say that I have pointed out that the major obstacle to be encountered in conducting staff in-service training will be the time that it takes away from regular duties. Compensating returns are not immediately perceptible to the harried director or bureau chief and are not easily demonstrated. The rewards that we seek are postponed rewards to be collected progressively over a stretch of time. Development is a slow process. However, even planning takes time, and chiefs and supervisors are expected to spend time in planning. The training of people is in the nature of planning and has equal value.

Faced with the necessity of answering the challenge of encroachment on staff time, it is obvious that haphazard, makeshift programs of in-service training will not justify themselves. The structure of training must be soundly conceived, and the training program conscientiously carried forward. Training develops the individual staff member. The quality of the program is but the reflection of the quality of staff responsible for the program.

LOS ANGELES APPROVES PUBLIC HEALTH BOND ISSUE

Citizens of Los Angeles voted their health department out of the "horse and buggy era" with a resounding "yes" vote for the provision of modern public health facilities in a municipal election during May.

A proposition calling for a \$6,500,000 bond issue for the construction of a central health department headquarters building and six district community centers was approved by the necessary two-thirds majority.

The bond issue also calls for the construction of a receiving hospital as part of the new central health department facilities.

A citizen's committee armed with facts supplied by the health department conducted an extensive campaign in support of the measure including newspaper and radio publicity, and "trailers" in motion picture theaters.

POLIOMYELITIS "PREPAREDNESS" MEETINGS HELD IN TWO CITIES

Closely following the pattern developed during the 1946 outbreak of poliomyelitis in Los Angeles, plans have been made at meetings in Los Angeles and San Francisco for the mobilization of community resources in the event of an emergency anywhere in the State this year.

Participating in the planning session called in Northern and Southern California were representatives of the State Department of Public Health, local health departments, hospitals, the National Foundation for Infantile Paralysis, the American Red Cross, and other interested groups.

Items discussed at the meetings included provision of facilities for hospital care during the acute phase of the disease, care after the isolation period, recruitment and training of technical personnel, orientation of nonmedical personnel, provision of additional equipment, follow-up programs, coordination of publicity and other related subjects.

The incidence of poliomyelitis for 1947 is running ahead of last year's figures, but many cases were reported in the first three months of the year and are thought to be a carry-over from 1946.

During the first three months of 1947, 175 cases of poliomyelitis were reported to this department as compared with 98 for the first three months of 1946. Through June, of this year, 350 cases have been reported. A total of 218 cases were reported for a similar period in 1946.

NURSERY EDUCATION CONFERENCE

The National Association for Nursery Education will hold its biennial conference in San Francisco August 26-30.

Headquarters for the convention will be at the Frederic Burk School of the San Francisco State College.

Those desiring further information should contact Mrs. Helen Marchand, San Francisco State College.

NUTRITIONIST EXAMINATIONS ANNOUNCED

Examinations for both grade one and grade two nutritionists will be given by the State Personnel Board on August 12, 1947. Final date for filing applications is July 22d.

Application forms and further information may be obtained from a local office of the Personnel Board, or from the State office, 1015 L Street, Sacramento.

PRELIMINARY REPORT OF HOSPITAL SURVEY ISSUED

California hospital needs and a plan for meeting them are outlined in a preliminary report of the survey on hospital facilities made by State Department of Public Health. Authorized by the Legislature in the 1946 special session, the survey was conducted by Dr. P. K. Gilman with the assistance of an advisory committee appointed by Governor Warren under the chairmanship of George U. Wood, superintendent of Peralta Hospital, Oakland.

The report states that 125,545 hospital beds are needed in California of which 66,860 are at present available making a shortage of 58,685 beds.

Biggest shortage is in beds for patients with mental disease. There are at present 27,450 hospital beds available in the State for these patients and an additional 18,800 beds are needed.

Recommended also are 14,100 additional beds in general hospitals, 15,000 additional beds for patients with chronic diseases, 3,035 beds for tuberculous patients, and 7,750 beds for convalescent patients.

Of equal importance to providing more hospital beds is the strategic location of new hospitals and their coordination with existing and other new facilities to insure that a patient anywhere in the State can receive the most highly skilled specialist services if he needs them, the report finds.

To achieve this end, a tentative plan for 18 regional hospital centers is presented to be documented in detail in a future supplementary report which will also present findings of the survey of public health centers.

Existing and new hospitals in the 18 centers would be staffed with specialists and would be completely equipped. Each would serve a surrounding area and would receive patients referred by doctors and from smaller hospitals and service centers in that area. In addition, two of the regional hospital centers, San Francisco and Los Angeles, would serve also as teaching centers.

Under this plan, it no longer would be necessary for patients living in remote parts of California to travel half the length of the State to receive specialized care, since the same type of service would be available in each of the 18 centers. In addition, the strategic location of smaller community hospitals and service centers throughout the State would make emergency and general care readily available to everyone.

REGIONAL PLAN

Following is the suggested plan for the distribution of hospitals. Both existing and proposed new facilities are included.

Region 1. Regional hospital, Redding. Community hospitals or service centers: Yreka, Alturas, Duns-muir, Tule Lake, Cedarville, Adin, Bieber and Weaverville.

Region 2. Regional hospital, Eureka. Community hospitals or service centers: Crescent City, Fortuna and Garberville.

Region 3. Regional hospital, Chico. Community hospitals or service centers: Red Bluff, Westwood, Oroville, Willows, Gridley, Portola and Quincy.

Region 4. Regional hospital, Sacramento. Community hospitals or service centers: Woodland, Placer-ville, Auburn, Grass Valley, Marysville, Arbuckle, Roseville, Downieville, Truckee, Jackson and Colusa.

Region 5. Regional hospital, Santa Rosa. Community hospitals or service centers: Fort Bragg, Lakeport, Napa, Ukiah, Willits, Healdsburg, Calistoga and Petaluma.

Region 6. Regional hospital, Oakland. Community hospitals or service centers: Berkeley, Alameda, Vallejo, Pittsburg, Martinez, Richmond, Concord, Fairfield, Hayward, Livermore and Antioch.

Region 7. Regional hospital, Stockton. Community hospitals or service centers: Lodi, Tracy, Modesto, Sonora, San Andreas, Patterson, Oakdale, Los Banos, Mariposa, Markleeville, Merced, Turlock and Yosemite.

Region 8. Regional hospital and teaching center, San Francisco. Community hospitals or service centers: San Rafael, South San Francisco, San Mateo and Redwood City.

Region 9. Regional hospital, San Jose. Community hospitals or service centers: Palo Alto, Watsonville, Santa Cruz, Santa Clara, Los Gatos, Gilroy and Centerville.

Region 10. Regional hospital, Fresno. Community hospitals or service centers: Madera, Selma, Han-ford, Visalia, Tulare, Porterville, Coalinga, Reed-ley, Dinuba, Corcoran and Lindsay.

Region 11. Regional hospital, Salinas. Community hospitals or service centers: Monterey, Hollister and King City.

Region 12. Regional hospital, Bakersfield. Community hospitals or service centers: Taft, Wasco, Delano, Tehachapi, Mojave, Ridgecrest, Lone Pine, Bishop and Bridgeport.

Region 13. Regional hospital, Santa Barbara. Community hospitals or service centers: Santa Maria, Paso Robles, Santa Paula, Ventura, Oxnard, San Luis Obispo and Lompoc.

Region 14. Regional hospital, San Bernardino. Community hospitals or service centers: Redlands, Riverside, Corona, Blythe, Elsinore, Uplands, Indio, Banning, Palm Springs, Victorville, Bar-stow and Needles and Loma Linda.

Region 15. Regional hospital, San Diego. Community hospitals or service centers: Escondido, Na-tional City, Brawley, Oceanside and Calexico.

Region 16. Regional hospital and teaching center, Los Angeles. Community hospitals or service centers: Santa Ana, Fullerton, Anaheim, Montebello, Cul-ver City, Santa Monica, Beverly Hills, Burbank,

Van Nuys, San Fernando, Palmdale, Glendale, Alhambra, Pasadena, Monrovia, Covina, Pomona, Whittier, Huntington Park, Compton, Long Beach, San Pedro, Torrance, Inglewood, Laguna Beach, Avalon and four within Los Angeles City and North County.

Region 17. (Alpine Co.) Regional hospital, Yerington, Nev. Community hospital or service center: Markleeville.

Region 18. (Southeast corner Inyo Co. and Northeast corner San Bernardino Co.). Regional hospital, Las Vegas, Nev.

EDWARD A. REINKE APPOINTED CHIEF OF SANITARY ENGINEERING

Mr. Edward A. Reinke has been appointed Chief, Bureau of Sanitary Engineering, effective July 1, 1947.

Mr. Reinke's appointment follows 27 years of service in the Bureau of Sanitary Engineering.

A graduate in sanitary engineering of the University of California, the new chief has spent practically his entire professional career in public service. Aside from his many years with the department, Mr. Reinke's experience includes service with the United States Army in World War I, work with the State Highway Commission and United States Forest Service, and one year as a civil engineering instructor at Santa Clara University.

Mr. Reinke succeeds Mr. C. G. Gillespie, who retired in January, as chief.

INFLUENZA "A" VIRUS ISOLATED

Two localized outbreaks of influenza "A" have been reported among school children in Madera and Fresno Counties.

The virus of type "A" influenza has been isolated in a ferret from the throat washings of a case in Fresno. This is the first virus isolation during 1947.

BERKELEY OFFICES MOVE

Several of the Berkeley units of the State Department of Public Health, including headquarters offices of the Bureaus of Sanitary Engineering and Vector Control, and a branch office of the Bureau of Maternal and Child Health, are now located in the Federal Farm Credit Building, 2180 Milvia Street, Berkeley.

The move was necessitated when the building previously occupied by these groups was seriously damaged by fire several months ago. In the interim the units were housed at 2002 Acton Street. The phone number for Vector Control and Sanitary Engineering will remain the same—Ashberry 7780.

VECTOR CONTROL BUREAU ESTABLISHED

A Bureau of Vector Control has been established in the Division of Environmental Sanitation, State Department of Public Health.

Mr. Frank M. Stead, Chief of the Division, will serve as acting chief. The new bureau will include mosquito and rodent control sections.

LOCAL HEALTH OFFICER CHANGES

F. E. Wiggins, M.D., has replaced Frank M. Gardner, M.D., as the health officer of the City of San Bernardino.

Dr. Philip A. Bearg has resigned as health officer of San Luis Obispo County. A replacement has not as yet been appointed.

ALL OLIVE OIL PREPARED IN CALIFORNIA MUST CONFORM WITH STATE LAW

The Attorney General has upheld the view that the California Olive Oil Law, which forbids the blending of other edible oils with olive oil, is equally applicable to products prepared for sale within or solely outside of the State.

The opinion was made in response to a request by Senator Jack Tenney of the State Legislature.

"The object of the Olive Oil Law," the opinion states, "is not only the protection of the health of the people of the State, but the protection of California industry. California may regulate the quality of olive oil produced within the State despite the fact that such regulations may have the effect of prohibiting the introduction into interstate and foreign commerce of olive oil not complying with such standards."

The Olive Oil Act of 1943 makes it unlawful to mix or blend other edible oils with olive oil so as to create an imitation or blended olive oil product.

COSTA RICA SMALLPOX REGULATION

The Republic of Costa Rica has established a special smallpox immunization requirement which provides that no person will be permitted to enter or leave that country without a certificate of successful smallpox immunization.

The community-wide chest X-ray survey, a technique of casefinding both rapid and thorough, is waging a highly effective war against tuberculosis.—Francis J. Weber, "Community-Wide Chest X-rays Surveys," *Public Health Reports*, May 2, 1947, p. 658.

PORTION OF SANTA MONICA BAY BEACH QUARANTINE LIFTED

After a quarantine which lasted more than four years, approximately four and one-half miles of Santa Monica Bay beaches have been released from quarantine by the State Board of Public Health.

Approximately seven and one-half miles of beach remain under quarantine from Sunset pier in Venice on the north to 27th Street in Manhattan Beach on the south.

This action was taken following a report by the department's Bureau of Sanitary Engineering which found that chlorination of the sewage at the Hyperion outfall has decreased pollution of beaches on the northern and southern limits of the quarantined area.

Bacteriological study and inspection of the area will be continued. If findings indicate any part of the beach area again becomes polluted, the quarantine will be extended.

Santa Monica's beaches were first quarantined by the State because of sewage pollution on April 3, 1943, and the limits were extended on October 13, 1945, when it was found the pollution was spreading. Action by the State Board releasing a portion of the beaches from quarantine came on June 23d of this year.

On February 1, 1946, the State won a suit against Los Angeles and satellite cities. Chlorination, which was started May 15th, is a first step in settlement of the judgment which also requires additional plant and outfall sewer facilities. These are now under construction.

SIERRA REGION RELAPSING FEVER STUDY TO CONTINUE

Rodent surveys and tick collection work initiated last year in connection with the study of relapsing fever in the Sierra region will be resumed this summer. Operations were discontinued last fall because of poor weather conditions.

The study is being carried out by units of this department in conjunction with the University of California's Hooper Foundation, the California Department of Agriculture, the Nevada State Department of Health, the U. S. Public Health Service.

In addition to rodent and tick sampling, literature will be distributed to residents and vacationers in the Sierra region advising the institution of vector control measures.

An attempt will also be made to contact physicians in the area and to remind them that a .06 gram dose of mapharsan intravenously is a specific cure for relapsing fever. Reporting of all cases will be an aid to further control measures.

DR. CUNEO RETIRES AFTER 31 YEARS AS HEALTH OFFICER

Dr. Peter Cuneo, who recently retired as health officer of the City of Bakersfield after 31 years and 11 months of service in that capacity, is now devoting his entire time to private practice.

Dr. Cuneo was the first health officer of Bakersfield and holds the record for length of service as a local health department head in California. Under his administration the first public health nurse in the county was employed and programs were developed in tuberculosis and other communicable disease control, sanitation, and other phases of public health. The first public health laboratory in Kern County was established in the early days of his service. Many of the services developed under Dr. Cuneo's administration have been expanded to include the entire county.

Dr. Cuneo retired on April 3d of this year when public health activities in Bakersfield were placed under the Kern County Health Department.

INFECTIOUS SYPHILIS RATES IN FIVE INDUSTRIAL AREAS COMPARED

In a comparative study of California's five major industrial areas, Venereal Disease Service statisticians have found that during 1946 San Francisco had the highest infectious syphilis rate.

Rate for San Francisco was 105.5 per 100,000 residents while the rate for the total State was 65.2 last year. A total of 873 cases of syphilis in primary and secondary stages in the San Francisco area were reported to the State Department of Public Health. Total cases of this type for the State was 6,007 in the same period.

Los Angeles City had the second highest infectious syphilis rate last year with 98.4 cases per 100,000 population. Following the City of Los Angeles was the county (figures for city included), its rate being 66.3.

Contra Costa County had a rate of 60.9, and Alameda County, the lowest, 59.4.

More than half of the State's population is located in these industrial areas. A table summarizing these data is below.

NUMBER AND RATES OF PRIMARY AND SECONDARY SYPHILIS CASES REPORTED IN SELECTED INDUSTRIAL AREAS AND TOTAL CALIFORNIA, 1946

<i>Area</i>	<i>Number</i>	<i>Primary and secondary syphilis</i>
		<i>Rate per 100,000 population</i>
Alameda County	423	59.4
Contra Costa County	173	60.9
Los Angeles City	1,777	98.4
Los Angeles County	2,377	66.3
San Francisco County	873	105.5
Total California	6,007	65.2

PROPOSED SCHOOL HEALTH RECORD FORMS COMPLETED

To meet the need for adequate and uniform school health record forms throughout the State, a subcommittee of the Department of Public Health and Education's Joint Committee on School Health has drafted two forms for use in the school health program.

The proposed cards will be used on a trial basis in an urban and a rural school for six months. If proved adequate, they will then be made available to all schools which may wish to use them.

One of the forms is designed for the student's medical and nursing record, the other for teacher observation of the child's health. The latter will serve as a cumulative school health record for the child.

The record forms were drafted following conferences and discussions with leaders in this field, both local and State.

JOINT SCHOOL HEALTH COMMITTEE ISSUES NUTRITION BULLETIN

A bulletin on nutrition education, *Objectives of Nutrition Education at Different Grade Levels* has been issued by the Joint School Health Committee of the State Departments of Public Health and Education.

Designed for teachers, the bulletin was prepared to assist teachers in incorporating nutrition education in the curriculum. The objectives are listed in the bulletin as habits (or skills), attitudes, and knowledge which most children are capable of mastering at the different grade levels.

A brief listing of methods of nutrition education is also included.

GUIDE TO HEALTH ORGANIZATION ISSUED BY U. S. P. H. S.

A long-needed handbook of health organization in the United States has been issued by the United States Public Health Service under the title *Guide to Health Organization in the United States*. The publication may be obtained for 20 cents from the Superintendent of Documents, Government Printing Office, Washington, 25, D.C. It has been issued as *Miscellaneous Publication No. 35*.

Compiled by Joseph W. Mountin, Medical Director, and Evelyn Flook, Administrative Analyst, United States Public Health Service, the handbook is a ready reference guide to the functions of the many United States health agencies. Contributions of federal, state, and local official and voluntary health agencies, and of private physicians, nurses, and dentists, are included.

CALIFORNIA MORBIDITY REPORTS SELECTED DISEASES—CIVILIAN CASES

Total Cases for May and Total Cases for January Through May, 1947, 1946, 1945 and 5-Year Median (1942-1946)

Selected diseases	Current month				Cumulative			
	May				January through April			
	1947	1946	1945	5-Yr. medium 1942 1946	1947	1946	1945	5-Yr. medium 1942 1946
Chickenpox (varicella)	4,486	3,847	7,200	5,283	27,010	17,588	33,422	28,967
Coccidioidal granuloma	5	5	2	-----	27	18	17	-----
Conjunctivitis—acute infectious of the new-born (ophthalmo-neonatorum)	2	11	3	-----	10	25	9	-----
Diphtheria	53	89	81	81	431	560	533	533
Dysentery, bacillary	8	12	16	-----	52	79	130	-----
Encephalitis, infectious	3	5	3	3	22	17	23	21
Epilepsy	109	146	150	-----	712	674	689	-----
Food Poisoning	54	75	5	-----	209	199	78	-----
German measles (rubella)	253	2,751	2,621	1,285	10,477	8,625	-----	-----
Influenza, epidemic	82	65	61	136	653	5,111	445	2,336
Jaundice, infectious	9	12	31	-----	56	89	120	-----
Malaria	8	56	11	12	49	380	49	45
Measles (rubella)	908	14,987	7,700	14,987	4,440	53,940	23,153	51,806
Meningitis, meningococcic	30	40	72	72	157	313	405	405
Mumps (parotitis)	2,175	3,667	5,900	5,614	10,204	13,666	25,701	20,630
Pneumonia, infectious	96	137	277	277	888	1,327	1,965	1,965
Poliomyleitis, acute anterior	54	34	9	28	263	152	51	108
Rabies, animal	22	49	99	88	132	204	331	323
Rheumatic fever	66	76	74	-----	388	316	356	-----
Scarlet fever	450	825	1,755	825	2,950	4,482	8,361	4,482
Septic sore throat	37	-----	-----	-----	299	-----	-----	-----
Smallpox (variola)	-----	-----	-----	0	2	7	3	6
Tuberculosis:								
Pulmonary	703	708	912	708	3,885	3,139	3,448	3,163
Other forms	65	54	61	46	268	191	247	163
Typhoid fever	8	12	11	13	38	56	32	56
Typhus fever	2	-----	1	-----	12	17	14	-----
Undulant fever (brucellosis)	31	39	40	30	117	133	117	101
Whooping cough (pertussis)	1,570	513	2,373	1,401	4,689	2,236	7,968	6,700
Venereal Diseases:								
Chancroid	38	58	18	-----	271	216	100	-----
Gonococcus infection	2,372	2,786	2,482	1,763	13,620	13,077	10,993	7,481
Granuloma inguinale	10	5	3	-----	42	15	21	-----
Lymphogranuloma venereum (lymphopathia venereum, lymphogranuloma inguinale)	12	17	22	-----	95	83	101	-----
Syphilis	1,944	2,204	2,641	2,451	10,581	10,197	11,560	11,560

DR. J. B. ASKEW MOVES TO SAN DIEGO

Dr. J. B. Askew, Chief of the Bureau of Hospital Inspections since it first began operation in January of 1946 has resigned from the staff of the State Health Department to become the assistant health officer of San Diego County.

Dr. Askew will serve under Dr. Alex Lassen, San Diego County Health Officer.

1
f
1
f
1
=